

Louisiana State Board of Medical Examiners

P. O. Box 30250, New Orleans, LA 70190-0250

Telephone: (504) 568-6820



Transfer of Certification

Name of supervising physician: _____

Name of group practice: _____

Business address: _____

Telephone number (_____) _____ - _____ Ext. _____

Specialty: _____

Supervising physician signature

Date

Name of physician assistant: _____

License (#): _____ Date Issued: _____

Business address: _____

Telephone number : (_____) _____ - _____ Ext. _____

Date of employment: _____

Physician assistant signature

Date

Name of previous supervising physician: _____

License number: _____

Group name: _____

Business address: _____

Telephone number: (_____) _____ - _____ Ext. _____

Date of termination: _____